

acetone bodies in the breath and urine (with the fatty changes in the liver often found in these cases). He claims that these latter conditions can be explained by the acute starvation involved with cyclic vomiting, and that the cause of the vomiting is elsewhere, probably in the hypertrophic stenosis of the pylorus. While actual stenosis of the pylorus is not an essential factor in the disease, he submits that the attacks were due to the occurrence of pyloric spasm. On this hypothesis, as long as pyloric spasm lasted obstruction would be complete. If it persisted long enough, acute starvation would necessarily follow with the resulting acidosis. Fatal issue followed on the inanition and exhaustion. While possibly not a factor in all cases, pyloric spasm is enough to account for recurrent attacks of vomiting and presents all features described as characteristic. It is also consistent with the fact that the attack often comes on suddenly. Relaxation of the spasm would be followed by this sudden cessation of the attack, which is often a noticeable feature.

An Epidemic of Acute Poliomyelitis.—W. W. TREVES (*Brain*, 1909, xxxii, 28) records the occurrence of an epidemic of 8 cases of acute anterior poliomyelitis in Upminster, a town of 1700 inhabitants. It was the first epidemic of its kind in the town, and no case of infantile paralysis had occurred there in several years. The months of the epidemic were hot and dry, but the heat was not excessive. Six of the patients had constitutional symptoms and a few days afterward were paralyzed; one child had fever, but developed no paralysis; the eighth was paralyzed without any constitutional symptoms. The legs were the members most commonly affected. In some of the children the eyes attracted the parents' attention by their peculiar look, but in no case was any definite evidence of polio-encephalitis obtained. Seven of the children were over six years of age, one was three and one-half. In 5 of the cases the period of incubation could not have been more than six days. All attempts to trace the means by which the disease spread failed. Of 32 other epidemics recorded in literature and discussed by the author, but 2 occurred in England.

The Dwarf Tapeworm, an Intestinal Parasite in Children.—OSCAR M. SCHLOSS (*Archiv. Pediat.*, 1910, xxvii) reports 14 cases of dwarf tapeworm or *Hymenolepis nana*, in 230 children. The average length of the worm is from 14 to 16 mm. The distal half is broad, while the proximal half becomes narrow. The segments are from 3 to 6 times as broad as long and the head of the worm is globular and carries four suckers and a rostellum armed with twenty or thirty bifid hooklets. Its habitat in man is in the upper two-thirds of the ileum. The eggs are slightly oval and have two membranes widely spaced. From the poles of the inner membrane are projections from which spring filaments which ramify in the space between the membranes. This is characteristic. The 230 children examined were from the tenement-house district, and, with one exception, were all born in New York City. Six of the 14 cases observed showed no symptoms referable to the parasite. The remaining 8 cases showed gastro-intestinal and nervous symptoms. Under the former, epigastric pain, nausea, vomiting, and an increased appetite were prominent. Restlessness at

night, grinding the teeth, itching of the nose, and genital pruritus under the latter. Eosinophilia was present in 7 of the 8 cases suffering from symptoms of the parasite. In cases with no symptoms eosinophilia was uniformly absent. A secondary anemia was generally present. The absence of, and variety in, symptoms are probably due to the site of mechanical irritation in the intestine and to toxic effects. The mode of infection is through ingestion of the ova in food. No intermediate host has been found in any human food. The dwarf tapeworm, however, has frequently been found in the small intestine of rats. Auto-infection is possible, owing to the great number of ova in the feces. The diagnosis is made by finding the characteristic ova in the feces or by obtaining the parasite after treatment. The treatment consists of a preliminary period of two or three days on liquid diet, a preliminary purge and the administration of oleoresin of male fern in mixture, emulsion, or capsule. The dose for a child two to four years old is 0.5 dram; four to six years, 40 grains; and six to twelve years, 1 dram. This is given on an empty stomach. It is divided into three or five doses and given at half-hour intervals. A brisk cathartic is given a half an hour after the last dose is taken. When the treatment is not effective the ova reappear in the feces in fifteen days.

OBSTETRICS.

UNDER THE CHARGE OF

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The Diagnosis of Puerperal Septic Infection.—SACHS (*Zent. f. Gynäk.*, No. 46, 1909) gives the result of 200 examinations of lochial discharge and blood in septic cases. This study was made to determine the significance of hemolytic streptococci in the blood as well as in the lochial discharges. He agrees with Veit that serious puerperal septic infection is caused by these organisms, which are present in the great majority of cases. By using fluid blood agar media he was able to recognize hemolytic streptococci in two-thirds of the cases. It is not sufficient to recognize a few of these organisms to make a diagnosis of infection. Their presence must be sought in the blood and their frequency estimated. When puerperal ulcers with hemolytic streptococci are present the prognosis is better than if peritonitis has developed. Recognition of hemolytic streptococci in healthy puerperal patients has absolutely no significance with regard to their importance in cases of sepsis. When these germs are not found in a septic patient, the prognosis is good. As an exception to this, are those cases late in the puerperal period in which hemolytic streptococci have passed from the uterus and have caused suppuration in thrombosed veins, and are no longer recognized in the secretion of the uterus; also in cases of sinus thrombosis and other intercurrent affections in which the streptococcus is the active agent.